Key contacts

• Child, Youth and Family
  www.cyf.govt.nz
  0508 FAMILY (0508 326 459)

• The National Collective of Independent Women's Refuges
  www.womensrefuge.org.nz
  04 802 5078

• Doctors for Sexual Abuse Care (DSAC)
  www.dsac.org.nz
  09 376 1422

• Police
  www.police.govt.nz

• National Network of Stopping Violence Services
  www.nnsvs.org.nz
  National Office 04 802 5402

• Preventing Violence in the Home
  www.preventingviolence.org.nz
  0508 384 357

• Jigsaw
  www.jigsaw.org.nz
  0800 228 737

• Child Protection Services (CPS)
  www.cps.org.nz
  07 838 3370

• Family Start
  www.familyservices.govt.nz
  04 978 4239

• Plunket
  www.plunket.org.nz
  0800 933 922

• Barnardos
  www.barnardos.org.nz
  04 385 7560

• Parentline
  www.parentline.org.nz
  07 839 4536

• Rape Prevention Education
  www.rapecrisis.org.nz
  09 360 4001 (Office) 09 360 4004 (Crisis)

• Sexual Abuse Help Foundation
  www.asah.org.nz
  09 623 1700

• Open Home Foundation
  www.ohf.org.nz
  04 586 1077

• Child Abuse Prevention Service NZ Inc. (CAPS)
  04 801 2704

• Relationship Services
  www.relate.org.nz
  0800 RELATE (0800 735 283)
How New Zealand health professionals are treating family violence as a health issue.
Making the difference

A defining question for any health system is how to ensure the best possible service to the people in our care. Indeed, in the face of many competing and compelling demands even establishing the right measurements of progress can itself be a challenge. But there is now widespread recognition that responding successfully to family violence will be one of the most profoundly effective interventions many health professionals will ever offer.

Certainly, the scale of the problem is compelling, and for health services it produces significant costs. Aside from physical injury, exposure to family violence increases risks of suicide attempts, drug and alcohol abuse, and poor mental health by two to four times. The full human toll is perhaps only known by the individuals affected.

Health professionals cannot cure all society’s ills. But in this booklet we tell stories of lessons learned and very successful interventions. Strikingly, victims of violence often say that simply being asked if they are at risk is in itself an important benefit. Programmes of systematic intervention are helping more women and children through referrals to support agencies. Very often health staff who have completed training programmes report new confidence and satisfaction in now dealing successfully with a formerly difficult area.

The Ministry has been proud to support this progress. We are impressed by the gains that have been made in recent years. In launching the VIP we are building on the programmes we have supported to date. We look forward to continuing to be part of a health sector where, collectively, I believe we are all already making an important difference.

Stephen McKernan
Director-General
Ministry of Health
August 2007

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Intervention that works

As the case studies in this booklet attest, there are many good reasons to view family violence as a health issue. Health professionals are often the first to see victims when they most need help. Effective early intervention for children is very powerful in reducing long term harm. Family violence also imposes big strains on health services. But perhaps the most pressing point is also the most human. Health professionals are people we can trust to care for us when we are vulnerable – people who will help us get better. And over recent years New Zealand health professionals have achieved some remarkable progress in rising to the challenge of providing good care for victims of violence and abuse.

For many, this has meant entering unfamiliar territory, but it has also brought considerable new pride. Following simple processes to identify and refer people in need can change or even save lives.

Certainly, family violence remains very widespread in New Zealand. And the health system response is only a part of the picture. But we have been among the leaders in moving on from simply raising awareness to establishing systems to support intervention that works.

A first step was to make sure that we offered care for all family members. It is so common for both children and mothers to be victimised that we needed to make sure we could offer support to both.

Being a victim of violence still carries a stigma, so we also learned that as health professionals we need to take the lead in asking about violence and abuse rather than expecting victims to approach us.

For young people, family violence increases risk of suicide attempts, drug and alcohol abuse and mental health problems by two to four times. Adult victims use health care services at three times the rate of others and the health impact increases the longer abuse continues.

When the Ministry of Health published the Family Violence Intervention Guidelines in 2002 based on research by Dr Janet Fanslow at the University of Auckland, it was taking a strong leadership role. And, as set out in this booklet (see page 3), the leadership of individual health professionals and organisations has produced very strong progress over the last five years.

For me, one of the most satisfying aspects of being involved in this programme has been the opportunity to see the professionalism and care with which health professionals have taken up this work. With the launch of the VIP, we are delighted that the Ministry has provided additional funding as we take the programme up another level.

In ten years time I believe sound family violence intervention will be accepted by everyone as a completely routine part of health care. The issue remains pressing, but there is every reason for confidence in continued strong progress.

Jo Elvidge
Project Manager
Ministry of Health
Violence Intervention Programme
The Health Sector and Family Violence in New Zealand: Problem and Response

Problem

Family violence is a widespread problem affecting the lives of many adults and children. Lifetime estimates of child abuse suggest 4-10% of New Zealand children experience physical abuse, and 24% of girls and 11% of boys experience sexual abuse.(1,2)

Child physical abuse increases the risk of a range of mental health problems by around two to four times; suicide attempts by up to four times; alcohol abuse by around two times; and impaired relationships by around four times.(3,4)

There is a very high correlation between witnessing family violence against another adult in the last year and suicide attempts, depression and anxiety – attempted suicide rates are about four times higher among young people who have witnessed family violence.(5)

Studies involving community-based surveys within developed nations indicate the proportion of older persons experiencing abuse or neglect is 3-10% of the older population.(6)

Response

In November 2002 when the Ministry of Health launched the Family Violence Intervention Guidelines: Child and Partner Abuse they were endorsed by all the major health professional colleges.

Since then, DHBs have adopted an internationally developed audit process for measuring responsiveness to family violence. Progress across the sector over the last five years has included:(7)

- Audited DHB responsiveness to child victims of family violence has improved by 49%
- Responsiveness to partner abuse has improved by 150%
- Over 4,500 health professionals have been trained in family violence intervention
- Plunket has screened 29,200 new mothers for violence and made 600 referrals for child or partner abuse
- In the last 12 months 500 GPs and midwives have been trained in family violence.

(5) Fleming et al., 2007.
Miranda Ritchie
National VIP Manager for DHBs

“In my role as the National VIP Manager I draw on my experience as a registered nurse and Family Violence Intervention Programme (FVIP) coordinator for an existing, successful DHB FVI programme. There are many lessons from this experience that have informed the national programme. It is critical to have the support of senior clinicians and managers within the DHB. Staff need training and ongoing support in order to ask the hard questions of patients. Working in partnership with your colleagues in community family violence organisations greatly strengthens the programme – we can’t do this on our own! You must teach and practise partner abuse and child abuse intervention together because they are two sides of the same coin. And audit, ongoing evaluation and feedback are very important – anything less than a comprehensive systems change model won’t work.

In the national role I provide practical support about FVI implementation to DHBs, as they establish their programmes. Nationally, it is exciting to see DHBs developing systems and processes that are supporting effective family violence intervention. Clearly, there is wide acceptance in health that family violence is our problem and a growing commitment to address it.

The National Network of Family Violence Intervention Coordinators (FVICs) was established in 2003 and has become part of the national programme. We share strategies including resources, policies, training packages and evaluation findings. Our meetings twice a year are an opportunity to learn from each other and support family violence intervention programmes nationally.

I believe that as health professionals we have a responsibility to provide timely interventions for family violence as we would for any health issue. It’s great to see this becoming the universal view.”
Dr Denise Wilson (Tainui affiliation)
Senior lecturer in Nursing and family violence survivor

“I regularly teach nursing students about family violence. But it’s an issue I also know about first-hand. When I was a nurse in an intensive coronary care unit, I got used to making excuses for the black eyes and bruises I came to work with. This went on for years. The assaults might have eventually killed me.

Things reached a climax when I went to the Emergency Department with a face covered in bruises and a broken jaw. I was unable to answer the questions I was asked in an open ward cubicle while I was assessed by staff. I was so totally traumatised I couldn’t even think about what had happened, let alone answer questions. I was sent home the same day.

It was only later, when I was asked a direct question after an attack that I started to see a way out of the trees. When I took off the sunglasses that were masking a black eye, a colleague said to me, ‘He’s beating you isn’t he?’

Nobody had ever put it in terms like that to me before. And I thought, ‘Yeah, that is what he is doing.’

Being actually asked about the violence was a turning point. I didn’t want to end the relationship and I was frightened of losing the children. Self-blame can be extraordinarily powerful.

It took me months to even think about what happened that night and even longer to talk about it. I kept telling myself, ‘This is all my fault. I must be such a bad person to be deserving this all the time.’

So it’s important to ask and ask in the right way. People trust nurses. And if you ask a woman in a genuine non-judgmental, sensitive manner they are more likely to disclose than they are to just voluntarily self-disclose without any questions.

That can be the first step in saying you are actually a valuable person and you don’t deserve this.”

Background
Once a victim of partner abuse herself, Dr Denise Wilson is a registered nurse with clinical experience in intensive care/coronary care, medicine, and primary health care nursing. She is currently a Senior Lecturer in Nursing at Massey University and has researched in the area of family violence. She has also been involved in making sure that family violence training is included in undergraduate and postgraduate nursing and health curricula.
Charlotte Leslie
Plunket nurse

“When I asked the question on a routine Plunket visit, she just looked at me and she said, ‘Can we close the door?’ Then it all came out.

He hit her just once, about two years ago. But often since then her husband has raised his hand as if about to strike. He stops her going to playgroups and checks her cell phone. Her fear is compounded by isolation because she’s a migrant, with her family overseas. And socially, with the couple both in high status jobs, the subject of family violence isn’t likely to come up.

She wasn’t able to speak before because her mother-in-law was always around. So I said, ‘Okay we need to get some strategies in place’. I gave her contacts for Preventing Violence in the Home and advice on a lawyer, and called her again when it was possible to talk freely by phone.

When Plunket nurses were first asked to screen for family violence, I was horrified. I mean how do you ask someone you are meeting for the first time that kind of question? But now it’s actually quite straightforward.

I don’t know what will happen for this woman next. But we will continue to see her and have given her a few options. So she’s got something in place if she needs it.”

Background
Charlotte Leslie is a registered nurse and worked in a public hospital from 1983. She has now been a Plunket nurse for 10 years.

Research
There is substantial overlap between child abuse and partner abuse, in 30-60% of families where either child maltreatment or adult domestic violence is occurring one will find that the other form of violence is also present.


Plunket has screened 29,200 new mothers for violence and made 600 referrals for child or partner abuse.

Over 4,500 health professionals have been trained in family violence intervention.
Dr Russell Wills

Paediatrician

“Working as a community paediatrician, I see one or two new children every week who have been scarred by witnessing violence to others in the home or have experienced actual abuse themselves.

The consequences of experiencing violence can be bleak for children. There’s a profound life-long effect. Little children become fearful and anxious. They don’t learn that adults are reliable and trustworthy, and that becomes a core part of how they think. High rates of mental illness, early unwanted pregnancy and alcohol and drug abuse follow in train.

Act early enough, however, and you can see good gains. Intervention success rates for these children at preschool are 80%. They are 60% at age eight, but fall to 20% by the time someone reaches their teens.

So the object is to identify families as early as possible. Routinely including a question about domestic violence, and asking the parents how they parent their children is critical. To identify child abuse you usually need to look at the whole family.

I also sometimes wonder what happens to a woman in a violent relationship who doesn’t get asked about it. What does it mean for her to come in with injury, depression, severe child behaviour, and not have that question asked?

If you’re not asking, you might be wasting time on other interventions that won’t work. And also missing a chance to turn a potentially damaged child’s life around.”

Research

New Zealand research indicates that child physical abuse increases the risk of a range of mental health problems by around two to four times; suicide attempts by up to four times; alcohol abuse by around two times; and impaired relationships by around four times.


Background

Russell Wills has lectured at the Wellington School of Medicine, been the National Paediatrician for the Royal New Zealand Plunket Society and been a member of the Royal Australasian College of Physicians’ Community Child Health Specialist Advisory Committee. He contributed to the Ministry of Health’s Suspected Child Abuse and Neglect Guidelines for General Practice (2000) and New Zealand Family Violence Intervention Guidelines (2002). He is currently Clinical Director of the Maternal, Children and Youth Continuum at the Hawke’s Bay District Health Board.
**PARTNER ABUSE RISK ASSESSMENT: ASSESS PATIENT SAFETY**

1. Is the abuser here now?
2. Is patient afraid of their partner?
3. Is patient afraid to go home?
4. Has physical violence increased in severity?
5. Has anyone physically abused the children?
6. Have the children witnessed violence in the home?
7. Threats of homicide?
8. Threats of suicide?
9. Has partner ever tried to strangle?
10. Is there a gun in the house?
11. Alcohol or substance abuse?

Discuss a safety plan

**PARTNER ABUSE REFERRAL OPTIONS:**

1. Someone to support you: Family/friends, Family violence services, e.g. Women’s Refuge, National Network of Stopping Violence Services
2. Somewhere safe to stay: Family/friends, Women’s Refuge
3. Legal options: Protection orders you contact family violence services, e.g. Women’s Refuge, National Network of Stopping Violence Services, Police

**PARTNER ABUSE BRIEF INTERVENTION**

1. Identify abuse (use direct question)
2. Support and empower victim
3. Assess risk (Dual assessment, includes assessing safety of children living in the home)
4. Safety plan and refer
5. Document, current or past injuries
6. Referral to FV agencies

*Only screen when it is safe to do so - patient alone in a private area, or with children under 2*

Remember to assess for child abuse if concerns exist.

**Research**

Women who had experienced intimate partner violence (IPV) in their lifetime were two times more likely than women who had not experienced IPV to have visited a healthcare provider in the previous four weeks.


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“I’m not at all the type you would expect to tolerate abuse...”

“People tell me that I come across quite confidently – not at all the type they would expect to tolerate abuse. But when I first met my boyfriend with his nice soft voice he didn’t seem the type to inflict abuse either.

It began with mind games. He would deliberately let my dog out so I’d have to pay a fine for its straying. Then came constant verbal attack, pummellings and sexual abuse. It seems incredible, but I was convinced I was somehow to blame.

When I fell pregnant, I would cry when I saw my family doctor and the midwife, but they didn’t ask any questions or offer help. It was a hospital social worker, who I’d been referred to for a potential abortion, who proved the catalyst for change: simply by asking directly if violence was part of my life.

I think if someone is attacking your very character eventually it changes you. You start thinking, ‘Oh, it must be something that I am doing wrong.’ But once you have said, ‘Yes I have been abused,’ there is no turning back, no denying it any more.

The social worker gave me a card and said, ’Phone these people and they will help you.’ It took me out of that denial. Once I had said it out loud I couldn’t retract it.

It wasn’t until quite a while after that I phoned the number she gave me. But I often say to my friends now that if it hadn’t been for that lady asking me then I wouldn’t be here.”
"As General Manager of Clinical Services my areas of responsibility include Women’s and Children’s Health.

Five years ago, when the Auckland District Health Board was asked to pilot family violence screening at National Women’s, we had a poor understanding of the issue and believed we needed to buy in expertise. This led to us employing a contractor to run the project. It became obvious this wasn’t the way to go. We recognised that we needed to build our own expertise. Then we appointed an internal team of three: two staff and one from Preventing Violence in the Home. And from there we have made really good progress.

We learned that it has to be an in-house activity, reported at board level and filtering back through the organisation. The key is getting the right personnel, getting credible enthusiasts, and having senior leadership involved.

At the outset, to be honest, we were just doing it because we were a pilot site for the Ministry. However, as our understanding grew we quickly realised what an important issue it is for health.

You can have a family that are in need of help but just don’t get offered any. But once the offer is there it can make a very real difference. The fact that a lot of women say ‘thank you for asking’, you know you are doing the right thing; for them and for their children who are often suffering abuse as well.

But it’s a longer-term outcome and most people in the health services are used to seeing immediate cause and effect. Someone has appendicitis, so you take the appendix out, and they get better. Family violence is generally not so immediately apparent. Occasionally you will encounter a woman who discloses and needs urgent help. But most often it is not like that. I think that’s why a lot of staff struggle with the question ‘Why is this my job?’

Training is as important as is having the right questions to ask. Staff need to feel confident asking the questions and this only comes with experience. It is essential to provide ongoing support not just at the beginning.

It is also important to recognise that as major employers DHBs will have employees who experience violence in their home lives. We have to provide support for our staff through the DVFree programme as well as our patients. We also need to support our primary care colleagues. We are just beginning to address this in the coming year.

We’ve been incredibly lucky. We’ve got the right team and the right mix of skills. The enthusiasm has just been wonderful as people are starting to see the difference we can make."

Background

Kay Hyman is General Manager - Clinical Services (Women’s and Children’s Health, Cardiac Services and Operating Rooms and Anaesthesia) at the Auckland District Health Board. She has extensive health management experience including the last five years as General Manager of Women’s and Children’s Health.
Nathalie Tiatia

Family Violence Intervention Coordinator

“I’m the newest Family Violence Intervention Coordinator. I am Ngāi Raukawa, Te Arawa, Cook Island Māori, Welsh, Scottish. I started at the Taranaki DHB in May 2007. Before that, I was a registered nurse, and have had experience within community helping agencies. I was trained in areas of Family Violence by Tu Tama Wahine O Taranaki. I feel very positive about the gains that can be made for people in my new role. I’ve seen that for many families, big changes often start with small steps.

Many people have sad stories, very personal stories, but one thing people could hang on to was that it wasn’t only happening to them. They learned there are supports out there and that family violence is preventable.

When people are entrenched in the cycle of violence, it’s not easy for them to say, ‘I am going to change this tomorrow, I am going to hand in my notice and I am going to have a lifestyle change.’

A lot of people don’t want to keep repeating that cycle. They don’t want their children to walk the same path as they have and this is true for men too, they just don’t know how.

I believe it is best practice toward good health care to help people with that process. ‘The goal is stopping family violence … and saving lives.”

Background

After training as a registered nurse, Nathalie Tiatia worked in mental health and community assessment services with a Māori focus. She is now the Family Violence Intervention Coordinator for the Taranaki District Health Board.

Research

Family violence has also been associated with broader health consequences:

“The prevalence rates from this study and the strong associations with multiple physical and mental health effects suggest that intimate partner violence may be as significant a factor as poverty in terms of contributing to ill-health.”

CHILD ABUSE & NEGLECT

PRELIMINARY RISK ASSESSMENT

1. Family Violence
2. Parent indifferent, intolerant – view child as particularly troublesome
3. Severe social stress
4. Severe isolation and lack of support
5. Parents abused as children
6. Alcohol and drug use
7. Mental illness including post natal depression
8. Parent very young
9. Frequent changes of address, more than 2 over last year
10. At risk family actively avoids family support agencies

1. IDENTIFY

Take a thorough history for child abuse and neglect if concerns exist or if abuse is disclosed.

Red Flags:
- Uncorroborated history e.g. discrepancy between; history/injury history/developmental age
- Inappropriate parent response
- History of CYFS engagement
- Delay in seeking medical advice
- History of repeated trauma
- Varying/changing history

Assessing questions
Who makes the rules at home?
What happens if the rules are broken?
Do you ever fear for your child’s safety?

CHILD ABUSE & NEGLECT

RISK ASSESSMENT & REFERRAL

- Nature of abuse and/or neglect
- Trend of abuse; constant, increasing or decreasing
- Details of: how, where, when, who saw it happen
- Are adequate protectors available e.g. adult (family/other) who will keep the child safe
- Safety of sibling(s) in household
- Child’s ability to protect self e.g. baby/young child
- Other agencies involved with the family

CONSULTATION / SUPPORT
- Paediatrician / Senior clinician in child protection / CYFS

REFERRAL
- CYFS (0508 326459)
- Police (111)

CHILD ABUSE & NEGLECT

BRIEF INTERVENTION

1. Identify: take a thorough history if high risk &/or there are signs/symptoms suggestive of abuse
2. Provide emotional support for identified/suspected victims
3. Assess risk (including co-occurrence of partner abuse)
4. Safety planning and referral
- If immediate safety concerns call Police and refer to CYFS
5. Document, current / past injuries
6. Referral to CYFS or specialist social service agency

Consultation is important:
Consult with staff trained in child protection e.g. Social Worker, Senior Nurse / Paediatrician, CYFS
Seek peer-support/supervision for self

ASSESSMENT

CHILD ABUSE & NEGLECT

Seek peer-support/supervision for self
Paediatrician /CYFS
- e.g. Social Worker, Senior Nurse / Consult with staff trained in child protection
- Consult with staff trained in child protection
- e.g. Social Worker, Senior Nurse / Paediatrician , CYFS
- Consultation is important:
- Consult with staff trained in child protection
- e.g. Social Worker, Senior Nurse / Paediatrician, CYFS
- Seek peer-support/supervision for self

Leanne Collier-Wilson

Social Worker

“I’ve been part of the child protection unit attached to Starship Hospital for two years. We’re a team of doctors, nurses and social workers and we try to make sure a clinician from each discipline is assigned to each patient we see. My own background is in social work. I was formerly with Child, Youth and Family and with other agencies. Onward referral is an important element of my job.

When you find someone affected by domestic violence, you need to think about who else is impacted by the abuse. It’s important to remember the wider family context and the other children, besides the patient in the consulting room. Often, too, I hear mums say, ‘The kids don’t see it; they don’t know it’s happening.’ But when we talk to the children, we find many are aware of violence and are emotionally affected by it, even if they don’t experience physical violence. They know it’s happening and they’re scared of it.

How do these kids make sense of living in a war zone? Some feel that’s not fair. Other children in the family they also make disclosures of indecency and physical abuse.

In most instances there is more than one victim. The point I would stress is that partner abuse and child abuse go hand in hand. And if you want to make a positive difference you need to look for and respond to both.”

Background

Leanne Collier-Wilson has worked for Child, Youth and Family during her varied social work career spanning two decades. She has been in the multi-disciplinary child protection team at Starship Children’s Health, Te Puaruruhau, for two years.
David Pyper

Family Violence Intervention Coordinator

“I was a member of the Police for 16 years. For six years I was a police prosecutor in an advocacy role. I’m now a Family Violence Intervention Coordinator for the Otago District Health Board. I believe there are real gains to be made in reducing what for many families is a regular toll.

When I was a policeman I knew that if I was going to get seriously injured or killed it would most probably be at a family violence incident. This is where emotions run high.

It is important to look for controlling behaviour. That’s where it can escalate from. Does he hold all the finances, is he jealous, does he isolate you from your family and friends? These are all warning signs.

I’ve seen cases where women have said, ‘Enough’s enough.’ There’s a change, and it’s quite remarkable.

I always say, how can you measure an outcome if a woman finds herself a job, becomes more independent, or feels safe? If their children are well fed and happy? It’s hard to measure these things. But over time I believe we’ll see the change.

Research indicates that people who have experienced family violence are very much more likely to use mental health services or attempt suicide – and this disparity persists for many years even after the violence has ended.

Intervention can mean change before people are seriously injured or killed – or simply an improvement in people’s quality of life.”

Background

A policeman for 16 years, David Pyper has tertiary qualifications in Psychology and Sociology. He is now the Family Violence Intervention Coordinator for the Otago District Health Board.

Research

In a large study conducted in the United States adults who had experienced four or more categories of exposure to adverse childhood experiences compared to those who had experienced none, had four to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt.


Audited DHB responsiveness to child victims of family violence has improved by 49%.
“I registered as a nurse in 1982. My husband and I were also involved in Christian ministry work, and we went to Canada for a while and worked with indigenous Canadians. I have worked in primary health care for over 10 years.

I come from a very traditional Christian Samoan family. Compared with some families I have seen, I had a very sheltered and protected upbringing. Yet we all got disciplined when we were growing up because that was the norm. When you see it in the context of being unacceptable behaviour, however, it becomes a different story. We need to make that shift in thinking.

We are seeing a change today whereby people are taught how to parent their children and avoid violent situations. Real progress is being made, but we also have to acknowledge that families are under a lot of stress and sometimes they may revert back to behaviours they have been role-modelled.

I think health professionals often have constructs around what families should be like, based on their own upbringing. But when you are invited into people's homes, you begin to see that all families operate and live differently. You become aware of the poverty that some families are living in, the anxiety about finding work, the stress of obligation to their Pacific community.

Being a health professional, you are in a position of influence. Families may be more open to listening to you. If you allow violence in the home to happen and don’t say anything, you are condoning it. But if you step in at an early stage, you can influence change for the family.”

Background

Hilda Fa’asalele is a Registered Nurse and worked within Plunket as a Plunket Nurse, Clinical Educator and as the Pacific Services Development Manager. She is now at the Auckland District Health Board as the Pacific Health Manager for Auckland City Hospital. Hilda is also on the Ministry of Social Development Pacific Advisory Group to the Family Violence TaskForce.
"I’m 19 years old. When I was 14 I got into a relationship, which went on for three years. I basically lived at his house in the Auckland area, neglecting my schooling, friendships and family. He was slightly older than me, very smart, quite shy and reserved, doing well in the technical field when we first met. Then he got into drugs and completely changed. I was only young and I didn’t understand that stuff.

The domestic violence began after the first year. He completely lost it and started hitting me in the car, and it went from there. He thought I was cheating, and the abuse got really bad. He would beat me up so I couldn’t stand and then he would spit on me. There was a lot of emotional stuff too. He controlled everything. I had no money, he took my cell phone away from me, and I wasn’t allowed to see my friends.

His attacks could last on and off all weekend, strangling me and punching me around the body. Although members of his family were in the same house, they never said anything about it. Abuse was well known in their family and they were in denial about it. He was too cunning to touch my face because he realised that if I walked around with bruises people would know. There were times when I was trying to get out of doors because he wouldn’t hurt me away from the house where people could see.

Every time he beat me up I thought I had to get away, but he would always apologise, and I would go back to him because I had nobody else. A year or two after it started happening I tried to take my own life. I went into a very mild psychiatric ward for a week, I had a nurse at home with me 24/7, and I continued to see a psychiatrist for about two years. But the focus was always on my mental health. I was never given any advice about how to keep myself safe.

Apart from the times I was obviously bashed up and went to hospital, the only time the abuse ever just got asked about was recently when I went to Family Planning.

I was blown away when I heard that health professionals are now routinely asking people questions. It’s good to be aware. At least I now know help is there if I need it.”
“One morning when my colleague and I were together in the office, a young woman turned up unannounced at our maternity unit. She was very slight and obviously distressed. We brought her into our office and shut the door, making a safe place for her. We sat her down and she started to tell us what was happening.

Her child was about 11 months old. She had been through our services earlier and the staff member who had cared for her was concerned that her home was unsafe. This had been her only contact with our services, but all our staff routinely ask women who come for maternity care whether they are safe in their current living situation, have they ever been physically, sexually or emotionally violated. This woman answered no to those questions, but the staff member had had some concerns and said, ‘If you ever need anything, we are always here, 24 hours.’

We learned that she was living close-by. Her partner was abusive to her both physically and emotionally. He wouldn’t allow her to speak to him. She had to communicate with him by text-messaging even when they were in the same room. When his mates came round, she had to stand in the corner with downcast eyes, saying nothing, looking only at him, waiting for her next order. She had left the baby in the house and run to the hospital, afraid that neighbours might see her and dob her in to her partner.

We contacted the relief social worker, who was very prompt and sensitive. He recognised the family name, knew the woman’s aunt, and ran to her house to get her assistance. Aided by the police, they managed to extricate the child from the house. We linked the young woman with Women’s Refuge and safe accommodation was arranged, re-united with her baby. We were delighted by the real level of cooperation between staff and their willingness to respond quickly when needed.”

Judy Sulikosky
Maternity Services Coordinator

Background
Judy Sulikosky is Midwife Coordinator at the Hawke’s Bay District Health Board. She has received violence prevention training and support from the DHB that she says has transformed her practice.
Gene Chase
DVFree, and trainer for Preventing Violence in the Home

“The DVFree programme is all about empowering people who have been victims, giving them information and asking them what they want to do with it. I got involved in this work partly because I’m a former victim myself. I was taken out of home as a young fella because my dad was using me as a football. I was removed from Wellington and placed in Hamilton for a couple of years. When my mum and sisters visited me during the holidays, I would always ask, ‘Can I come home now?’ And Mum would say, ‘Not yet.’ Because my dad was killing me.”

DVFree and other community programmes

DVFree is a nationwide workplace programme, which helps employers develop policy and procedures to ensure that workers affected by violence at home get assistance and support.

Along with DVFree, community programmes supported by the Ministry of Health include:
- Promoting Youth Non-Violence: organisational change programme for education, sporting and religious organisations
- Dating Violence Prevention: a school-based programme aimed at preventing dating violence
- Whānau violence-free marae programmes: to train Māori health and social service providers
- Cool Schools: a peer mediation and conflict resolution programme run through schools
- Whakatokia te Rongomau ("plant the seed of peace"), a kohanga reo-based peaceful parenting programme
- BodySafe Programme: provides information on sexual violation and self-protection in high schools in the Auckland region for students in Years 9-13.

Background

Part of the DVFree team since April 2006, Gene Chase has a background of 17 years in the police force, including one year as an instructor at the Royal NZ Police College. He was also a coordinator of the Māori Sudden Infant Death Syndrome (SIDS) programme for the North Island, which involved running education programmes and training police, clinical and community workers on SIDS response and prevention.
Dr Rita Middleton

Family Doctor

“I’ve been in general practice in Masterton for 20 years. In my experience, repeated nebulous or diffuse complaints are often a pointer to something wrong outside the body. Patients might complain of muscular-skeletal symptoms one minute, then they might go into the gastrointestinal tract; then they’ve got pelvic pain.

If you’ve done what you need to do to rule out serious pathology, then you start to realise the problem may lie in a different area. And that’s when you start to ask questions about how things are going at home, and if they have ever been hit or punched. And quite often that becomes a very fruitful line of enquiry.

Nor does it need to take long. I recently referred an elderly woman to successful community intervention for a violent husband in the course of an 11-minute consultation.

It isn’t Pandora’s Box if you know what you are doing. It’s part of the training. You are not there to get them to bring out all the terrible things. You are there to affirm and to give advice and suggestions.

The woman just said to me, ‘I am so thankful you have asked that question, this has been going on for years.’

It feels like you are making a difference at the level where people live. And at a level where they haven’t been able to get help in the past quite often. So I feel I am maybe actually making a difference for the future not just for this minute in time. I find it very rewarding.”

Background

Dr Rita Middleton has been a family doctor in Masterton for 20 years. She is a member of DSAC and has worked with the police from referrals and closely with CYF in helping children who have been abused. She provides training to medical practitioners on best practice in the management of partner abuse and is part of the Training the Trainers group.

Research

Of the 2441 cases of abuse or neglect seen by Age Concern’s New Zealand elder abuse and neglect services between July 1998 and June 2001, most represented for psychological abuse (56%), followed by financial/material abuse (46%), physical abuse (22%), active and passive neglect (18%) and sexual abuse (3%).


An audit of four experienced GPs in New Zealand found that routinely asking women about their experience of family violence is acceptable to almost all women. Women were pleased to be asked and viewed this kind of inquiry as helpful. The time taken to assess these identified cases further averaged about three minutes for historic cases and between five and six minutes for those currently experiencing violence.

Doctors Sexual Abuse Care (DSAC), Audit of consultations from four GPs, 2005.
treating violence as a health issue
“We owe our children – the most vulnerable citizens in any society – a life free from violence and fear. In order to ensure this, we must be tireless in our efforts not only to attain peace, justice and prosperity for countries, but also for communities and members of the same family.” — Nelson Mandela


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